DEPARTMENT OF SOCIAL SERVICES
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October 5, 1979

ALL-COUNTY LETTER NO. 79-69

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: OUT-OF-HOME CARE SERVICES FOR CHILDREN AND AFDC-BHI -- EPSDT/CHDP REQUIREMENTS FOR CHILDREN IN OUT-OF-HOME PLACEMENT

REFERENCE:

Revised federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) regulations (copy attached), effective October 1, 1979, emphasize involvement of foster children in the EPSDT Program, a program of preventive health services for AFDC children provided in California through the Child Health and Disability Prevention (CHDP) Program. It is important that the revised regulations be carried out so as to ensure the best possible health services for foster children. They must also be complied with in order to avoid a one percent penalty against federal AFDC payments to the state. (See CFR Section 441.70 of the attached regulations.)

These revised regulations require the following:

1. The assistance unit, that is, the group home operator, foster parent, or other payee who receives the AFDC-BHI payment for the child is to be initially informed about the CHDP Program within 60 days of the determination of the child's eligibility for AFDC-BHI, and annually thereafter if the child is not participating in the CHDP Program. Informing must be done in writing, as well as by using face-to-face contact. (See CFR Sections 441.51 and 441.75.)

2. Documentation must be made that the information and brochure were given and that CHDP services are or are not requested. (See CFR Sections 441.71(a) and 441.90(b).)

3. Transportation and scheduling assistance must be offered. (See CFR Section 441.62.)

4. Acceptance or refusal of transportation and scheduling assistance must be documented. (See CFR Section 441.90 (b) (2) (iv).)

5. CHDP screening services must be completed and any necessary treatment services initiated within 120 days of the request for services. (See CFR Section 441.71 (a) (2) (i).)

In order to meet the requirements of these regulations, child placement staff will be responsible for the following:

1. CHDP information, including the CHDP brochure (available from the local CHDP programs), is given to the caretaker at the time of the foster child's first placement. Annual information on CHDP services available for children not involved in the CHDP Program must be done at alternate AFDC-BHI redeterminations.

2. Transportation and scheduling assistance is offered and the need for such assistance is determined by the placement worker at the time the information about CHDP is given the caretaker.

3. The following documentation must be readily identifiable in the service case record: (1) The provision of CHDP information and brochure; (2) the offer of transportation and scheduling assistance; (3) the decisions regarding the child's participation in the CHDP Program and need for transportation and scheduling assistance; (4) the date of the discussion and decisions. Until appropriate social services forms are developed or revised, it is suggested that documentation of initial informing be made on the agency's copy of the form, Agency-Foster Parent Agreement (SOC 156), or on the form, Agency-Group Home Agreement (SOC 154). For annual informing, documentation can be made on the placement worker's copy of the statement for income maintenance staff that a service plan exists.

4. If CHDP services are desired for the child, the placement worker is responsible to see that the child is referred promptly to the appropriate CHDP Program in the county where the child is placed so that the screening examination is completed and any recommended treatment is initiated within 120 days of the request for CHDP services.

Although federal regulations require that CHDP information be provided to the "assistance unit", it is the placement worker who is responsible for determining the needs of the foster child, arranging for medical and dental examinations as needed, and ensuring adequate medical care in accordance with Sections 30-206.111, 30-209.3, and 30-206.133 of Out-of-Home Care Services for Children regulations. Thus, it is the placement worker who actually makes the decision about ("request for") the foster child's involvement in the CHDP Program. The informing procedure entails the placement worker's planning with the "assistance unit" to obtain CHDP services for the child or explaining that the child will not be participating, if this is the placement worker's decision. Although participation in the CHDP Program is not mandatory, placement workers should obtain this preventive health service for foster children whenever possible.

Child placement staff are urged to contact their local CHDP programs for further information about the CHDP Program in their counties. Child placement staff should also coordinate with income maintenance staff in their county welfare departments regarding this transition of CHDP responsibilities in relation to foster children. (Please refer to All County Letter 79-68 dated October 1, 1979.) Changes will be made in appropriate state regulations to reflect the requirements of these federal EPSDT regulations and transfer of responsibility for informing and documenting from the income maintenance worker to the placement worker.

If you have questions regarding foster care responsibilities for child health, please contact Joe Lain, Chief, Family and Children Services Program Operations Bureau at (916) 445-7653. For information about CHDP informing requirements or help with working out individual county procedures, please contact your regional consultant in the EPSDT Program as follows:

Valley and northern counties - Eugen Barnett (916) 445-7653
Southern counties - Sylvia Novak (213) 620-5354
Coastal counties - Martin Warren (415) 540-2287

NOTE: "Placement worker" means the person who is responsible for choice of placement facility for each child, arrangements for placement, and supervision of the child in placement including follow up on his service plan. The reference is to the person's functions, not to his agency or title within the agency.

Sincerely,

JAMES H. GOMEZ
Deputy Director

cc: CWDA

federal register

Friday
May 18, 1979

Part XI

Department of Health, Education, and Welfare

Health Care Financing Administration and Office of the Secretary

Medicaid Requirements for State Programs of Early and Periodic Screening, Diagnosis, and Treatment of Individuals Under 21

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Health Care Financing Administration

42 CFR Part 441

Medicaid Requirements for State Programs of Early and Periodic Screening, Diagnosis, and Treatment of Individuals Under 21

AGENCY: Health Care Financing Administration (HCFA), HEW.

ACTION: Final regulation.

SUMMARY: This regulation revises and clarifies the Medicaid requirements for State programs of early and periodic screening, diagnosis, and treatment (EPSDT) for children under 21. It also revises the enforcement procedure under which a penalty may be assessed against a State that fails to meet minimum requirements, by reducing the Federal share of payments to the States for Aid to Families with Dependent Children (AFDC) by one percent. Experience with existing regulations indicates a need for greater clarity and for updating certain provisions.

EFFECTIVE DATES: October 1, 1979 for all section except § 441.56(a)(3), the screening requirement for developmental assessments, which is effective on January 1, 1981.

FOR FURTHER INFORMATION CONTACT: Mary Tierney (202) 245–7443

SUPPLEMENTARY INFORMATION:

Summary of Regulations

These regulations revise both State plan and penalty requirements applicable to the early and periodic screening, diagnosis, and treatment (EPSDT) program.

The new State plan requirements prescribe minimum elements to be included as part of screening examinations, specify that States must develop screening periodicity schedules for individuals up to 21 years of age, and specify that States must provide scheduling and transportation assistance to EPSDT families.

Penalty requirements revise procedures that States must employ to inform, screen and treat persons receiving cash benefits under the Aid to Families with Dependent Children (AFDC) program. Specifically, these regulations prescribe the manner, timing, and content of States' informing obligations. The regulations also specify steps States must take in providing referral assistance to individuals whose treatement needs do not have State plan coverage. Documentation requirements are specified as are the bases for the imposition of the penalty. States' performance will be measured against percentages for timely informing of families and timely service delivery to those persons who have requested EPSDT services.

Background

Since 1967 the Federal government has tried to design, implement and enforce a program that would assure comprehensive, preventive health care for Medicaid children. Major studies conducted during the early and mid-1960's demonstrated that permanent harm was done to the nation's poor children because treatable medical problems were not detected at early stages of the illness. In response to this concern we proposed and Congress passed, in 1967, a new section 1905(a)(4)(B) of the Social Security Act. This requires that States include in their Medicaid plans a program of early and periodic screening, diagnosis, and treatment of individuals under 21 who are eligible for Medicaid. The EPSDT program requires States to ascertain the children's physical or mental conditions, and to provide for health care, treatment, and other corrective health measures.

Congress expressed its concern about the slowness with which we and the States were implementing the EPSDT program by including in the Social Security Amendments of 1972 a penalty provision which would reduce by one percent a State's Title IV AFDC funds in a quarter during which it failed to:

"(1) inform all families in the State receiving aid to families with dependent children . . . of the availability of child health screening services [under Medicaid] * * *

(2) provide or arrange for the provision of such screening services in all cases where they are requested, or

(3) arrange for [directly or through referral to appropriate agencies, organizations, or individuals] corrective treatment the need for which is disclosed by such child health screening services."

This new provision, which became section 403(g) of the Act, gave the Federal government an expanded role in ensuring that each State successfully screened and treated those children who requested EPSDT services. In addition, it gave HEW an enforcement tool, the penalty of one percent of AFDC funds, which was easier to apply and less disruptive to the program than compliance action.

Since the passage of the 1972 amendments, we have attempted to issue regulations which penalize non-performing States and which grant complying States flexibility in program implementation. The initial implementing regulations were issued on August 2, 1974, one month after the penalty provisions took effect.

To address the problems which quickly became apparant in the initial regulation, we issued two Notices of Proposed Rule Making (NPRM): the first on August 20, 1975 (40 FR 36378) and the second on September 8, 1977 (42 FR 45276). These two NPRMs, were designed to: (1) Clarify requirements necessary to implement the EPSDT program; (2) revise the basis on which the penalty would be assessed; and (3) increase the effectiveness of the program.

The second NPRM was published rather than final regulations because the commenters responding to the 1975 NPRM offered varied and frequently conflicting points of view on all of its provisions. Based on the comments, we decided that the 1975 NPRM had not achieved its purpose. We then had meetings with 45 States, interest groups, and providers. As a result of these meetings we developed and published the 1977 NPRM. We received approximately 100 comments on it from various sources, including agencies in 26 States, 2 governors, 3 child advocacy groups, 3 legal organizations and 4 health professional organizations.

In addition to these comments, in October 1978 we consulted further with representatives of States, child advocacy groups and Congress. These further consultations focused primarily on how to convert some of the process requirements in the 1977 NPRM into performance standards. The principal areas affected were the sections on the application of the penalty and requirements for support services.

These final regulations were developed based on the cumulative knowledge acquired during the entire comment period.

Since the proposals in the 1977 NPRM superseded those published in 1975, all references in this preamble to "the NPRM" refer to the 1977 one.

There were five areas of major concern raised during this process:

A. Application of the penalty.

B. Informing eligible families.

C. Providing or arranging for EPSDT services.

D. Family's choice of provider.

E. Documentation.

A. *Application of the Penalty*

The NPRM proposed that the penalty would be imposed if EPSDT services were not delivered within 120 days of a request in at least 90 percent of the cases reviewed by HCFA. (The NPRM

also contained numerous exceptions, however.) Many commenters objected to this proposal. They did not believe that the 120-day period, even with the exceptions, was sufficient to complete initial or periodic screening and to initiate all necessary follow-up services. Provider scarcity and failure in States' case management systems were cited as reasons for the inability to meet the requirement. HEW recognizes the need for flexibility.

1. *Basic Provisions.* Commenters pointed out both the importance of the timely delivery of health care and the problems encountered by States in delivering this care. We have tried to achieve a balance among the need for specificity in order to facilitate enforcement, State needs for administrative flexibility, and eligible families' need for comprehensive, preventive health care.

The final regulation provides the following criteria for applying the penalty. For those cases in the sample—

(1) A State must have screened and begun treatment of at least 75% of the recipients who requested services within 120 days of the initial request or within 120 days of the date of a child's rescreening according to the State's periodicity schedule.

(2) A State must have screened and begun treatment of at least 95% of the recipients who requested screening within 180 days of the initial request or within 180 days of the date for a child's rescreening according to the State's periodicity schedule.

If less than 75 percent compliance is achieved within the 120-day requirement, we will assess the penalty. If the State complies with the 75 percent test, the sample will be further analyzed to determine whether service delivery was achieved within 180 days. If compliance is less than 95 percent within 180 days, we will assess the penalty.

2. *Scope of State's Responsibility for Timely Delivery of Services.* The issue of State versus family responsibility for the delivery of health care to a child who requests EPSDT services is complex and subtle. The NPRM addresed the issue by precisely defining what a State must do to discharge its share of the responsibility. After the State performed the required actions, the family became totally responsible. The State was required to make a follow-up within 150 days of the request for services, and to reoffer help with an appointment and transportation, if:

(1) A child, who had requested State assistance in getting services, did not keep the scheduled appointment, or

(2) A child who had not requested assistance in getting services did not schedule an appointment or keep a scheduled appointment.

Many commenters addressed this issue; most agreed that the State and the family each bear a share of responsibility. Many State officials stated that a State should not have to establish extensive case management systems either to ensure that a family kept a State-scheduled appointment or to ensure that a family made its own appointment after declining State-offered assistance. Some commenters stated that HEW was requiring State administrator to become paternalistic or coercive.

Other commenters pointed out that the manner in which States offer assistance influences the number of families who accept needed support services. In addition, the State, by scheduling either a convenient or inconvenient appointment, strongly influences the percentage of families who keep scheduled appointments.

We have resolved the issue of defining the relative responsibilities of the State and the family in the following way. First, the regulation does not make provision of support services (transportation and scheduling assistance) subject to the penalty in those cases where services are provided on a timely basis. Instead, they have been added as State plan requirements. This is not done to downplay their importance. Rather, it is done primarily to avoid the anomaly of taking a penalty, even though each child received EPSDT services, because support services were not offered or provided. Our approach thus serves to focus the penalty provision on outcomes rather than process requirements.

Second, we have established a high performance level of 95 percent for timely service delivery, which conforms to Congressional intent, and which, by being high, places primary responsibility with the State. Then, we deal with these circumstances for which the State is properly held to have fully discharged its obligations and the responsibility is borne by the family:

The State is not penalty liable for those cases for which it can show, with supportive evidence, that:

(1) The family lost eligibility; or

(2) The State was not able to locate the family despite a good faith effort to do so; or

(3) The child's failure to receive necessary services was due to an action or decision by the family, rather than a failure by the State to comply with the requirements of this regulation, including the obligation to provide the support services required by the State plan.

Thus, the State has the responsibility to make it possible for recipients to receive EPSDT services. It is then the family's responsibility to make use of them if they wish. If, for example, the State has evidence that it offered and provided requested transportation and scheduling assistance required under the State plan, and the child did not receive EPSDT services in a timely manner, the State will not be held at fault. Conversely, if the State does not have evidence that it offered and provided requested support services and the child did not receive EPSDT services in a timely manner, the State *will* be held at fault.

In keeping with our emphasis on outcome rather than process, we are not specifying the form of evidence that States must have to meet this requirement. However, since effective case management requires case records that would normally contain this type of information, we do not believe requirement places any undue additional burden on States.

We believe that this approach to penalty monitoring both provides for timely treatment of medical problems and accommodates difficulties that States might encounter in assuring timely service delivery.

B. *Informing Eligible Families*

Approximately 80 comments were received on this issue, principally concerning which families were to be informed and how.

1. *Methods of Informing.* The NPRM proposed to require States to use both face-to-face contact and written materials to inform families that are eligible for AFDC of the nature and benefits of the EPSDT program. Numerous commenters objected to the face-to-face contact provision. We intended this to apply only to families who have become eligible for the first time. In addition, the NPRM permitted a State to inform families at the intake interview, even though their eligibility had not been formally determined.

The fact-to-face requirement represents a compromise between home vists, the most effective means of informing families, and mass mailings, the least effective method. We recognize that home visits would require costly increases in manpower and other expenditures for States. We also realize that a weak informing requirement would reduce the effectiveness of the EPSDT program. Four years of EPSDT program experience show that there

must be face-to-face contact to ensure that clients are properly informed and that the outreach obligations of the program are fulfilled. Thus, we have retained the requirement to use both face-to-face contact and written materials. The face-to-face contact can take place at the intake interview or up to 60 days following AFDC eligibility determination. By allowing these options, we are giving the States the administrative flexibility that we and the commenters agree is needed. However, it is widely acknowledged that using the AFDC intake interview for EPSDT informing is the least effective method because the family's attention is concentrated on the need for cash assistance rather than on the benefits of a preventive health program. Therefore, we hope that States that now do more than the minimum required by the regulation will continue to do so, and that other States will begin to use effective techniques.

We have further clarified the informing requirement by specifying that face-to-face contact must occur both for families that have become eligible for AFDC for the first time and for those families that have regained AFDC eligibility after a period of ineligibility. It is not required when a State makes a periodic redetermination of eligibility for a family that has been continuously eligible. Moreover, in order to deal with the possibility that families may lose and regain eligibility for AFDC numerous times within a 12-month period, the State need not inform a family more than twice in a 12-month period.

2. *Categories of families informed.* Many commenters noted that neither the NPRMs nor the existing regulations mention specifically that children receiving AFDC foster care are eligible for EPSDT. The definition of "dependent child" in section 408(a) of the Social Security Act includes those dependent children of families for whom Federal payments for foster care are made. Therefore, these children are a mandated category of eligibles and were covered by the NPRM. However, for brevity, we have explicitly included AFDC foster care children in the definition of a "family" in the final regulation.

3. *Undecided Families and Families That Decline Services.* For families who were undecided about accepting EPSDT services at the time of initial informing, the NPRM proposed to require that States make one attempt to recontact them within 60 days after being initially informed and to document the outcome of the notification. We intended that this follow-up could be done either by telephone, face-to-face contact, or mail. In addition, the NPRM proposed to require States to inform families annually about the availability of EPSDT services if they had declined or did not use the services.

Some commenters objected to these provisions because they were perceived as coercive or paternalistic, or because they would require additional tracking by States. Other commenters believed that it was vital to recontact families who were undecided about accepting EPSDT services or who declined these services. The commenters stated that families are under stress at the time they apply for cash assistance and this often prevents careful consideration of the advantages of preventive medical care for their children. Also, many commenters believed that families who declined EPSDT services should be given an opportunity to reconsider this opportunity for preventive services.

The final regulation requires that a State recontact once each year all recipients who either decline the service or who were undecided. We believe this is necessary so that the family can reconsider its earlier decision not to use the services or can make a decision if the family was undecided earlier. By permitting States one year for contacting undecided families, the regulation enables States to use regularly scheduled mailings, telephone calls, or the more preferable practice of explaining the value of EPSDT at eligibility redetermination sessions or a home visit. The time required for reinforming families who decline services is the same as that for undecided families; consequently, States may use one system to notify both types of families.

4. *Informing families about periodic assessments.* The NPRM proposed to require States to inform families already in the EPSDT system of their children's eligibility for another screening. This informing procedure had to be in writing and within the frequency required by the State's periodicity schedule. Eighteen comments were received regarding this provision. Few objected to the concept of periodic notification, but did comment that a new system to track the families would have to be developed.

The final regulation does not require States to reinform families of their children's rescreening, because the rescreening itself is a penalty-liable event. This regulation requires that a State rescreen each child according to the periodicity schedule. How the State notifies the family can therefore be left to the discretion of the State.

5. *Informing families who have missed appointments.* Many commenters objected to the NPRM requirement that States recontact families who did not keep screening and treatment appointments which either the family or the State had scheduled. Some commenters pointed out that families should have responsibility for their own actions. Other commenters pointed out that State actions, such as scheduling convenient appointments or providing transportation, greatly influence the percentage of families who keep appointments. The balancing of family versus State responsibility was discussed earlier.

The final regulation does not require that States recontact families. It does, however, require the State to have a State plan provision dealing with support services. At this time, States have considerable discretion in how to provide these support services and, in particular, whether to recontact a family after a missed appointment. If subsequent studies show that more specificity is warranted, we will initiate further rulemaking.

C. *Providing or Arranging for EPSDT Services*

1. *Timely delivery of services.* The NPRM proposed to require that all requested screening and necessary treatment services be initiated within 120 days of the request for screening. Initiation of treatment was defined as the first encounter between the child and the health provider at which time treatment is begun for those conditions found as a result of screening. This meant, for example, if a child had three medical and two dental problems, that an initial visit to a doctor and one to a dentist had to occur within the 120-day limit. The requirement was intended to assure that eligible individuals receive EPSDT services and necessary treatment within a reasonable period, while allowing States time to devise flexible schedules for screening and treatment. Commenters believed either that the time period was too long or not long enough. Some wanted a continuation of the current regulation time limit of 60 days. Some agreed with the greater flexibility afforded by a single period, but others disagreed. Still others thought that the State should be responsible only for arranging an appointment for treatment within 120 days.

We think that a period longer than 120 days, or a requirement merely to arrange an appointment, would not reasonably

assure (1) that medical intervention would be beneficial for the treatment of conditions found during screening, or (2) that arrangements for delivery of complete screening services could be made in such a way that the family would maintain its continuing interest and motivation to keep appointments. We also know from experience that any period longer than 4 months between a request for services and the initiation of treatment increases the possibility that the family loses eligibility for Medicaid. A period shorter than 120 days would not allow sufficient time for States to deliver the full screening package and initiate all necessary follow-up treatment services for all eligible families that request services.

Some States thought that the NPRM would have required a substantial change in their mode of delivering health services. The final regulation requires screening and initiation of treatment within 180 days after the request for at least 95% of those who request services. In our view, based on our understanding of State programs, this will not require any major administrative modification in State procedures. In addition, some States alleged there is a scarcity of providers, especially in specialty services, and that this might preclude their meeting the requirements of this regulation. We believe that there are adequate resources available to meet the needs of the EPSDT program, if they are properly coordinated.

To accommodate varying State capabilities in assuring the timely delivery of services, the final regulation provides some flexibility by altering the percentages of cases subject to the time requirements. This system is fully discussed above under "Application of the Penalty." Also, the regulation specifies, as did the 1975 and 1977 NPRMs, that States will be required to provide both scheduling and transportation assistance to those persons requesting such help. These support services are applicable to both screening and treatment, as requested by the family.

2. *Referral for services not covered under the State plan.* Because States have the option of limiting the scope of their Medicaid program, it is possible that conditions will be discovered through screening for which there is no coverage for treatment under the State plan. However, Congress was clear in its direction that all persons having positive screening findings be treated and that a State be responsible for referring eligible children to other sources for treatment services that are outside the scope of the plan. (See Senate Report No. 92-1230, p. 298.) Therefore, the NPRM proposed to require States to provide referral assistance for treatment services not covered under the State's Medicaid plan.

Several commenters noted that the scope of the referral requirement was unclear. We have addressed these concerns by specifying that States must give families the names, addresses and telephone numbers of providers who have expressed a willingness to furnish services at little or no expense to the family.

3. *The use of "comprehensive care" providers.* The NPRM proposed to require States to verify that certain families were receiving services from "comprehensive care providers". A comprehensive care provider was defined as one who provides the full range of screening, diagnostic, and treatment services as well as medical case management. The intent of the provision was to encourage families to develop permanent provider relationships.

More than 50 comments were received concerning this issue. A majority of them objected to the special treatment accorded comprehensive care providers. The 1977 NPRM contained several exceptions from generally applicable requirements, because many commenters on the 1975 NPRM indicated a need to ensure that comprehensive care providers (such as Title V grantees) continue to give the preventive care they normally give and yet not have to meet some of the "process" requirements of the EPSDT regulations. We thought that this special treatment would stimulate more provider participation and lessen chances of duplication of services available through existing comprehensive care providers. However, strong objections were raised concerning this provision, focusing primarily on the fact that comprehensive care providers would have less accountability and that this provision would create a sizable monitoring burden on the States.

We agree that the proposed exceptions for special types of service delivery should be dropped. We do not believe that this should be interpreted, however, to mean that we wish to discourage the use of these comprehensive care providers.

Rather, we encourage States to make arrangements with comprehensive care providers for the delivery of EPSDT services and to make these providers accountable for compliance with Federal program requirements. In this manner, recipients may develop the kind of regular and direct relationships with the health care system that is generally not in evidence today. While current authority requires that States be held directly accountable to the Department for compliance with all EPSDT requirements, States are free within this framework to design and implement EPSDT delivery systems that meet their own particular needs.

4. *Screening services.* The NPRM outlined the minimum screening services which States must provide. Most commenters strongly supported the components of screening as proposed, but felt that States would need additional time and technical assistance to develop procedures for providing developmental assessments.

Basically, the regulation adopts the "screening package" as proposed in the NPRM. However, since States need time to formulate procedures for developmental assessments, this requirement will not be effective until January 1, 1981. We will issue guidelines covering the nature and scope of the assessments prior to the effective date.

In addition, in response to further review of our experience in the program and comments from recipient groups, we will require that States refer all medically screened children directly to a dentist for treatment. Despite considerable evidence which shows that 95% of screened children over 3 years of age require dental treatment, under current State practices only 25% receive it. Lack of proper dental care leads to the development of more serious and costly problems in adolescence and adulthood. Since almost all children over 3 need dental treatment, no purpose is served by continuing to require a separate dental screen. Therefore, we are eliminating the separate dental screening requirement and mandating the more efficient direct referral to a dentist.

D. *Family's Choice of Provider*

The NPRM provided that families could choose to continue to receive EPSDT services from their own health care provider. In such cases, however, States would have been required, within 120 days of a request for EPSDT, to verify which components of the screening package had been provided, along with the necessary follow-up treatment. In screening or treatment was imcomplete, States would have been required to provide those services in the screening package that these providers could not or would not complete. Many commenters objected to this provision

for two reasons: (1) Verifying services from private providers is difficult, if not impossible; and (2) the monitoring procedures needed to ensure case management for these families would be cumbersome and too costly.

We believe that States should provide a mechanism for allowing those families who are already receiving health care from their own providers to continue to do so. In no instance should the State interfere with the client's right to choose his own provider. Families should not feel that they are choosing between their own providers and EPSDT but, rather, that they can freely choose both.

In response to the many comments regarding this issue, the final regulation provides for a continuation of the family's relationship with its regular provider. It also includes a provision to assure that recipients receive the full range of EPSDT services by requiring States to offer families any EPSDT services which are not available from a provider and providing those services, if the family requests it.

E. *Documentation*

The NPRM specified the documentation States must make available to HCFA as evidence that the penalty requirements have been met. Comments about these requirements ranged from claims that no documentation is needed to suggestions that we add major additional categories of documentation. In many instances, however, commenters were unclear as to where records are to be kept and how much and what kind of evidence would be needed to document that the requirements have been met. The most frequent comment regarding the documentation requirements concerned the provisions for comprehensive care providers, which have now been eliminated.

The final regulation requires that States make written documentation available for review. Since the publication of the two proposed rules, States have generally made significant strides in maintaining much of the documentation that the final regulation now requires. For this reason, we expect that much, if not all, of the documentation needed by Federal monitors will be available at the State or local agency office. We recognize, however, that certain documentation may be located at the provider's office. Federal monitors will attempt to obtain these data; if they cannot, they will turn to the State to furnish the missing data. Documentation may be in the form of reports, claim forms, case records, or any other written material reflecting compliance with specific program requirements.

Recodification

Existing penalty regulations appear in 45 CFR 205.146(c). Since all other Medicaid regulations now appear in 42 CFR Chapter IV, Subchapter C, the penalty regulations are therefore revised and the Medicaid portion transferred to 42 CFR Part 441. Although the penalty is taken on AFDC funds, State Medicaid agencies are responsible for administering the EPSDT program. Therefore, we believe that regulations affecting this program more logically belong with all other Medicaid regulations. Amendments to 45 CFR 205.146(c) that reflect this redesignation are published today at page ——. In place of the detailed penalty regulations, § 205.146(c) now states that a one percent penalty on AFDC funds will be imposed if conditions in 42 CFR Part 441 are not met.

42 CFR Part 441 is amended as set forth below:

1. The table of contents for Subpart B is revised to read as follows:

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

* * * * *

Subpart B—Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21

Authority: Sec. 403(g), 1102 and 1905(a)(4) the Social Security Act (42 U.S.C. 603(g), 1302 and 1396(a)(4)).

Subpart B—Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21

2. Subpart B is revised to read as follows:

§ 441.50 Basis and purpose.

This subpart implements—

(a) Section 1905(a)(4)(B) of the Social Security Act, by prescribing State plan requirements for providing early and periodic screening and diagnosis of eligible Medicaid recipients under age 21 to ascertain physical and mental defects, and providing treatment to correct or ameliorate defects and chronic conditions found; and

(b) Section 403(g) of the Act, by specifying the conditions under which HEW will impose a penalty on States by reducing Federal financial participation under title IV–A of the Act (Aid to Families with Dependent Children), for failure to provide EPSDT services to eligible AFDC recipients under age 21. (See 45 CFR 205.146(c) for penalty reduction in AFDC.)

§ 441.51 Definitions.

For purposes of this subpart—

"Family" means an assistance unit receiving cash assistance under title IV–A of the Act and includes children for whom Federal payments for AFDC foster care are made.

"Initiation of treatment" means the first encounter for treatment of the medical and the dental problems disclosed during screening.

State Plan Requirements

§ 441.55 Basic requirement.

A State plan must provide that the Medicaid agency meets the requirements of §§ 441.56–441.62, with respect to EPSDT services, as defined in § 440.40(b) of this subchapter.

§ 441.56 Required services.

(a) *Screening.* The agency must provide for at least the following screening services:

(1) Health and developmental history.

(2) Unclothed physical examination.

(3) Effective January 1, 1981, developmental assessment.

(4) Immunizations which are appropriate for age and health history.

(5) Assessment of nutritional status.

(6) Vision testing.

(7) Hearing testing.

(8) Laboratory procedures appropriate for age and population groups.

(9) For children 3 years of age and over, dental services furnished by direct referral to a dentist for diagnosis and treatment.

(b) *Treatment.* In addition to any treatment services included in the plan, the agency must provide the following services, even if they are not included in the plan—

(1) Treatment for defects in vision and hearing, including eyeglasses and hearing aids; and

(2) Dental care needed for relief of pain and infections, restoration of teeth and maintenance of dental health.

§ 441.57 Discretionary services.

Under the EPSDT program, the agency may provide for any other medical or remedial care specified in Part 440 of this subchapter, even if the agency does not otherwise provide for these services to other recipients or provides for them in a lesser amount, duration, or scope.

§ 441.58 Periodicity schedule.

The agency must implement a periodicity schedule that—

(a) Is developed after consultation with representatives of recognized medical and dental professional groups;

(b) Specifies screening services applicable at each stage of the recipient's life, up to age 21, including a neonatal examination; and

(c) Identifies the time period, based on the recipient's age in years and months, that defines when screening services will be delivered.

§ 441.59 Administration.

The agency must—

(a) Identify available screening and diagnostic facilities; and

(b) Ensure that the services offered by these facilities are available for recipients under age 21.

§ 441.60 Identifying, informing, and referring eligible recipients to title V services.

The agency must—

(a) Identify those recipients eligible for EPSDT services who can obtain needed medical or remedial services through a grantee under title V of the Act (Maternal and Child Health and Crippled Children's Services); and

(b) Ensure that recipients eligible for title V services are informed of available services, and referred if they desire to title V grantees that offer services appropriate to the recipients' needs.

§ 441.61 Maximum utilization of existing services.

The agency must make maximum use of existing screening, diagnostic, and treatment services provided by public and voluntary agencies such as well-baby clinics, neighborhood health centers, rural health centers, rural health clinics, and similar agencies.

§ 441.62 Transportation and scheduling assistance.

The agency must offer to the family or recipient, and provide if requested—

(a) Assistance with transportation as required under § 431.53 of this chapter; and

(b) Assistance with scheduling appointments for services.

Penalty for Failure To Provide EPSDT Services

§ 441.70 Imposition of penalty.

For each quarter that a State fails to comply with the requirements to provide EPSDT services to AFDC recipients, as specified in §§ 441.71–441.90, HEW will reduce by one percent Federal financial participation in State payments for AFDC.

§ 441.71 Application of the penalty.

(a) HEW will impose penalties under this subpart if a State fails to maintain accurately the documentation required in § 441.90 or if a State fails to meet the following measures of compliance with the requirements of this subpart:

(1) In at least 95 percent of the sample cases reviewed by HCFA, the State has met all informing requirements as specified in § 441.75.

(2) For families or recipients that request EPSDT services, in at least 75 percent of the sample cases reviewed by HCFA, either—

(i) Screening must have been completed and treatment initiated, as specified in §§ 441.80 and 441.85, within 120 days after the initial request for screening or the date rescreening was due under the State's periodicity schedule; or

(ii) The State can show, with supportive evidence, that within the 120-day time periods, either—

(A) The family or recipient lost eligibility;

(B) The State was not able to locate the family or recipient despite a good faith effort to do so; or

(C) The recipient's failure to receive necessary services was due to an action or decision by the family or recipient, rather than a failure by the State to meet requirements of this subpart, including the requirement to offer and provide the support services specified in § 441.62.

(3) For families or recipients that request EPSDT services, in at least 95 percent of the sample cases reviewed by HCFA, either—

(i) Screening must have been completed and treatment initiated, as specified in §§ 441.80 and 441.85, within 180 days after the initial request for screening or the date rescreening was due under the State's periodicity schedules; or

(ii) The State can show, with supportive evidence, that, within the 180-day time periods, either—

(A) The family or recipient lost eligibility;

(B) The State was not able to locate the family or recipient despite a good faith effort to do so; or

(C) The recipient's failure to receive necessary services was due to an action or decision by the family or recipient, rather than a failure by the State to meet requirements of this subpart, including the requirement to offer and provide the support services specified in § 441.62.

(b) To determine if a penalty will be imposed, HCFA will use the following—

(1) Documentation compiled by the agency as specified in § 441.90;

(2) Sampling techniques; and

(3) Other procedures as HCFA finds necessary.

(c) Whenever a penalty is imposed under this section, the agency is entitled, upon request, to a reconsideration of the penalty in accordance with section 1116(d) of the Act and 45 CFR Part 16.

§ 441.75 Informing a family of the availability of EPSDT services.

(a) No later than 60 days following the date of a family's initial AFDC eligibility determination or of determination after a period of ineligibility, the agency must inform each family of the availability of EPSDT services. This must be done in writing and using face-to-face contact by a person who can explain EPSDT services and benefits. The agency need not inform any family more than twice in a 12-month period.

(b) If no member of an eligible family participates in the EPSDT program, the agency must inform the family in writing at least once each year beginning with [effective date of regulation].

(c) The agency must use each of the following to inform an eligible family:

(1) Clear, nontechnical materials for those families that are to be informed in writing.

(2) Procedures suitable for informing persons who are illiterate, blind, deaf, or cannot understand the English language.

(d) When informing a family about the EPSDT program the agency must give the following information—

(1) The benefits of preventive health services;

(2) How EPSDT services can be obtained;

(3) How specific information can be obtained on the location of the nearest providers participating in EPSDT;

(4) The screening services that the agency offers under its plan;

(5) A summary of the State's periodicity schedule;

(6) That recipients can receive both initial and periodic screening according to the State's periodicity schedule;

(7) That treatment services covered under the plan will be provided for problems disclosed during screening;

(8) That assistance in referral will be given for services not covered under the plan;

(9) That the agency will provide assistance with transportation, to the extent covered under the plan, if the family or recipient requests it;

(10) That the agency will assist in scheduling appointments if the family or recipient requests this assistance;

(11) That as long as the family or recipient remains eligible for AFDC, it may request EPSDT services at any time in the future if it chooses to postpone its decision at the time it is initially informed;

(12) (i) That the family or recipient may choose to receive EPSDT services from a provider of its choice; and

(ii) That if the provider does not offer the full range of EPSDT services as specified in the plan, the family or recipient can receive the services not offered, if the family or recipient requests them from the agency; and

(13) That the EPSDT services covered under the plan are available at no cost.

§ 441.80 Providing for EPSDT services.

(a) The agency must provide for at least those screening and treatment services as specified in § 441.56(a) and (b).

(b) The agency must provide screening services according to a periodicity schedule, as specified in § 441.58.

(c) If a family or recipient chooses to receive EPSDT services from a provider that does not furnish the full range of EPSDT services, the agency must, if requested, provide for all EPSDT services that are not offered by that provider. The agency must provide for such services in the manner specified in this section. In this case, the time frames specified in § 441.71(a)(2) and (3) begin on the date that the family or recipient requests the services from the State that are not offered by the provider.

§ 441.85 Referral for services not in the State plan.

The agency must provide referral assistance for treatment not covered by the plan, but found to be needed as a result of conditions disclosed during screening and diagnosis. This referral assistance must include giving the family or recipient the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family.

§ 441.90 Documentation.

The agency must have available, or make available upon request, the following written documentation at the State or local level for review:

(a) Administrative information:

(1) The agency's periodicity schedule.

(2) Written materials used to inform families.

(3) Procedures used to inform those who are illiterate, blind, deaf or cannot understand the English language.

(b) Records or information on services and recipients:

(1) Monthly lists or a sample of those lists as specified by HEW containing, for that month, names and case numbers of:

(i) newly approved AFDC cases;

(ii) AFDC cases where no member of an eligible family participates in the EPSDT program;

(iii) AFDC recipients requesting screening, and the dates of those requests; and

(iv) AFDC recipients due for rescreening under the State's periodicity schedule.

(2) For the cases comprising the sample drawn in paragraph (b) (1) of this section—

(i) Names of AFDC families informed of the availability of EPSDT services, either within 60 days of eligibility determination or on an annual basis, as specified in § 441.75(a) or (b), and the date they were informed;

(ii) Names of AFDC families or recipients who decline initial or periodic EPSDT services, and the date of that declination;

(iii) Names of AFDC families or recipients who choose to receive services from a provider who does not provide the full range of EPSDT services, the date on which they request services that are not covered by that provider, and the dates that these requested services are provided; and

(iv) Names of AFDC families or recipients who were offered and declined support services as specified in § 441.62, and the dates of offer and declination.

(v) Names of AFDC families or recipients who requested support services as specified in § 441.62, and the dates on which the agency provided this assistance.

(3) For each recipient screened by a provider who provides the full range of EPSDT medical services or dental services, or both—

(i) The name and case number of the recipient;

(ii) The dates of each screening;

(iii) The screening services provided and each screening finding, including findings on conditions needing follow-up treatment;

(iv) The dates on which follow-up treatment was initiated for those conditions requiring treatment; and

(v) The names of each recipient who required treatment for conditions not covered by the plan and the efforts to refer them to providers willing to treat them at little or no expense to the family.Q04

(Secs. 403(g), 1102 and 1905(a)(4) of the Social Security Act (42 U.S.C. 603(g), 1302, and 1396d(a)(4))

(Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Program)

Dated: April 4, 1979.

Leonard D. Schaeffer,

Administrator, Health Care Financing Administration.

Approved: May 14, 1979.

Joseph A. Califano, Jr.,

Secretary.

[FR Doc. 79-15629 Filed 5-17-79; 8:45 am]

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Office of the Secretary

45 CFR Part 205

Reduction in Federal AFDC Funds for Failure To Provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

AGENCY: Office of the Secretary, HEW.

ACTION: Final regulation.

SUMMARY: This amendment deletes requirements from title 45 specifying the conditions under which Federal AFDC funds will be reduced if a State fails to provide early and periodic screening, diagnosis, and treatment (EPSDT) under Medicaid for AFDC children. These requirements are revised and transferred to 42 CFR Chapter IV, Subchaper C, which contains other Medicaid rules. This rule is a conforming amendment to regulations in title 42.

EFFECTIVE DATE: October 1, 1979.

FOR FURTHER INFORMATION: Mary Tierney (202) 245-7443.

SUPPLEMENTARY INFORMATION: Requirements are now set forth in 45 CFR 205.146(c) that specify the conditions under which a one percent penalty must be levied against the

Federal share of AFDC funds for failure to provide EPSDT services. Published elsewhere in today's **Federal Register** is a regulation that revises and transfers them to 42 CFR Part 441, Subpart B of the Medicaid regulations. Since State Medicaid agencies are responsible for carrying out EPSDT program activities necessary to preclude imposition of the penalty, it is appropriate to publish the penalty regulations with other Medicaid requirements.

This is merely a technical amendment to conform with the Medicaid regulations which were previously published as a proposal with opportunity for public comment. I, therefore, find that there is good cause to waive notice of proposed rulemaking.

45 CFR 205.146 is amended by revising paragraph (c) to read as follows:

§ 205.146 Specific limitations on Federal financial participation under Title IV-A.

* * * * *

(c) *Penalty for failure to provide early and periodic screening, diagnosis and treatment of children under Title XIX of the Act.* Pursuant to section 403(g) of the Act, notwithstanding any other provision of this chapter, total payments to a State under Title IV-A of the Act shall be reduced by 1 percentage point (calculated without regard to any other reduction under this section), on a quarterly basis if the State fails to comply with the requirements set forth in 42 CFR 441.70 through 441.90.

(Sec. 1102 of the Social Security Act (42 U.S.C. 1302).)

(Catalog of Federal Domestic Assistance Program No. 13.808 Public Assistance—Maintenance Assistance (State Aid))

Dated: May 14, 1979.

Joseph A. Califano, Jr.,

Secretary.

[FR Doc. 79-15637 Filed 5-17-79; 8:45 am]

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